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ABSTRACT

This paper examines problems associated with psychiatric diagnoses. In the early 1960s, Karl Menninger and others prepared a treatise on the problems with psychiatric diagnosis, both from the standpoint of inherent weaknesses in the system and from an awareness of professional abuse of the system. The paper concentrates on three aspects of misdiagnosis: (1) inter- and intra-profession disputes over the proper target population and the complexity of intervention strategy; (2) the apparent imprecision in diagnostic classifications; and (3) professional dishonesty in assigning diagnoses for the sake of third-party payment. It is recommendd that the first issue be addressed by a major reconstruction of the diagnostic approach and by a cessation of attempts to define differences between and among subgroups of mental health professionals. Such changes would help correct the other issues by providing descriptive diagnoses which would permit more accurate support for selective intervention, enhance communication among professionals, and increase accountability. It would also inhibit unethical or dishonest diagnoses by employing a more responsive diagnostic system. The papers assert that until the profession decides to manage itself, there wi l always be the pressure to prostitute the profession and the clients in a system which values cost control over client service. (RJM)

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# The Vital Balance Revisited
## or
## Resolution of the Counseling Profession's Identity Split

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In the early sixties, Karl Menninger, et al. (1963) prepared a treatise on the problems with psychiatric diagnosis, both from the standpoint of inherent weaknesses in the system and from an awareness of professional abuse of the system. Theirs was a compelling argument against applying a medical model to psychological problems, made more convincing by virtue of the fact they are products of the medical community and thoroughly grounded in practices of medical diagnosis, prescription, and treatment.

> In the early part of the century the object of psychiatry was primarily to identify and distinguish the forms and evidences of mental illness, so little recognized in their minor manifestations and so vastly feared in their larger appearances. We dutifully employed historic designations and historic concepts associated with them. Today these concepts have been largely replaced by more dynamic, pragmatic notions. Our concern now is not so much what to call something as what to do about it. The old point of view assumed that most mental illness was progressive and refractory. The new point of view is that most mental illness serves its purpose and disappears, and does so more rapidly and completely when skillfully understood and dealt with.
>
> Instead of putting our emphasis on different clinical forms of mental illness, we tend today to think of all mental illness as being essentially the same in quality, although differing quantitatively and in external appearance (Menninger, K., et al., 1963, p.2).

The act of assigning names to psychiatric conditions has two potentially harmful results. It gives an illusion of a level of accuracy and understanding that is risky, both in the giver of the label and in others who presume to share the same meaning and accept the same conclusion about a patient whom they may not have encountered, and the pjorative nature of labels often causes damage to the bearers of those labels.

> Merely giving incomprehensible names to psychiatric conditions is somewhat reassuring in that it gives the impression that the condition is recognized and understood by *someone*. But it does not assist in the dispersal of this understanding. Furthermore, it introduces a new kind of fear, fear not of the actual condition as it exists but of the condition which is implied -- usually incorrectly -- by the exotic name. .... To call our technical language unattractive is almost a euphemism. Diagnostic name-calling may be damning. Applicants for college enrollment, life insurance, club membership, officer candidacy, graduate training, and other special privileges, can be quickly blacklisted by such labels as "psychopathy," "character disorder," and "schizophrenia." The applicant's appearance and his record of achievement are lost sight of. Nor does qualifying these damning labels with such adjectives as "latent" or "potential" or "borderline" undo the damage (Menninger, K., et al., 1963, p.44-45).

Menninger and his colleagues reframed mental illness from that typically understood in the diagnostic classificatory systems, both historical and contemporary. While not going so far as to disregard the term illness, as did Szasz (1961) who spoke of the *myth* of mental illness,

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they collapsed the multitudinous categories into a single quality with variations in quantity and behavioral manifestation.

> It is this view of mental illness as personality dysfunction and living impairment which is presented in this book. It sees all patients not as individuals afflicted with certain diseases but as human beings obliged to make awkward and expensive maneuvers to maintain themselves, individuals who have become somewhat isolated from their fellows, harassed by faulty techniques of living, uncomfortable themselves, and often to others. Their reactions are intended to make the best of a bad situation and at the same time forestall a worse one -- in other words, to insure survival even at the cost of suffering and social disaster (Menninger, K., et al., 1963, p.5).

Proceeding from the condition manifest by normal people who encounter challenges of living and invoke "normal coping devices," diagnoses can be made by describing patient or client behavior into one of five levels of dysfunction, the severity of which is determined by the "psychological cost" involved to insure survival. This approach was touted by them as being superior to the APA Diagnostic and Statistical Manual of Mental Disorder and the International Classification of Diseases Manual in use at the time, as well as former diagnostic nosologies. The problems of inaccuracy in assigning the diagnostic labels is handled in their system by using description of behavior rather than labels; similarly, the absence of labels precludes damages from their pjorative nature. The present generation of the Diagnostic and Statistical Manual retains labels, with their inherent weaknesses, although it includes additional scales intended to amplify or qualify the meaning of those labels; even though improved, the DSM-IV is open to the criticisms elaborated by Menninger, et al.

In their Therapeutic Psychology: Fundamentals of Counseling and Psychotherapy (1960), Brammer and Shostrum used a continuum of client characteristics as an aid to making distinctions between and among counseling, therapeutic counseling, and therapy. Therapy was seen as what psychotherapists do to and with their patients. Counseling was seen as less dynamic regarding personality change and more oriented to normal people who are experiencing difficulty with developmental transitions and interpersonal conflicts. Therapeutic counseling was alleged to bridge between the other two, applying therapy techniques to a clientele not sufficiently maladjusted to need psychotherapy (as in mental hospital patients) yet requiring more dramatic interventions than the typical purview of counselors.

Combining the view of these authors, a case could be made for a singular quality to mental illness or maladjustment with a range of complexity going from normal to severely abnormal. It could be alleged that the techniques for dealing with a similar range of behavior would, themselves, vary mostly in quantity. Counseling, therapeutic counseling, and therapy techniques would vary in *degree* or in *intensity* across the range of client/patient types from normal to severely abnormal. Perhaps counselors, therapeutic counselors, and therapists do the same kinds of things to/with their clients/patients with variations only in degree or intensity.

**Professional Identity Diffusion**

Menninger would encounter, were he alive today, the same set of dynamics about which he and his associates wrote. Some labels are different; the players include more than just psychiatrists. In the press for professioinal identity resolution, The American Psychological Association made a definition statement about counseling psychology and clinical psychology (1981).

> Clinical psychological services refers to the application of principles, methods, and procedures for understanding, predicting, and alleviating intellectual, emotional, psychological, and behavioral disability and discomfort (p. 642). [They include:] Assessment directed toward diagnosing the nature and causes, and predicting the effects, of subjective distress; of personal, social, and work dysfunction; and of the psychological and emotional factors involved in, and consequent to, physical disease and disability" (p. 642).

This statement appears to claim the purview of clinical psychology to be problems of maladjustment -- an abnormal or "disease" model -- and proscribing diagnosis, etiology, prediction (prognosis) and treatment as the procedural dynamics.

> Counseling psychological services refers to services provided by counseling psychologists that apply principles, methods, and procedures for facilitating effective functioning during the life-span developmental process. In providing such services, counseling psychologists approach practice with a significant emphasis on positive aspects of growth and adjustment and with a developmental orientation. These services are intended to help persons acquire or alter personal-social skills, improve adaptability to changing life demands, enhance environmental coping skills, and develop a variety of problem-solving and decision-making capabilities (p.654).

The purview of counseling psychologists appears to be variations from the norm in development.

These definitions permit some degree of differentiation, at least in theory, between the two specialties. As the statements proceed to interventions, the differences begin to blur.

> Procedures include individual and group psychological counseling ... and may use a therapeutic, group process, or social-learning approach, or any other deemed to be appropriate. Interventions are used for purposes of prevention, remediation, and rehabilitation. They may incorporate a variety of psychological modalities, such as psychotherapy, behavior therapy, marital and family therapy, biofeedback techniques, and environmental design (p. 654).

> Interventions may reflect a variety of theoretical orientations, techniques, and modalities. These may include, but are not limited to, psychotherapy, psychoanalysis, behavior therapy, marital and family therapy, group psychotherapy, hypnotherapy, social-learning approaches, biofeedback techniques, and environmental consultation and design (p.642).

One might question, if the repertoire of techniques is essentially the same, are the targets of those techniques also essentially the same. Is the profession giving different definitions to the same reality? Apparently Menninger's assertion of a unitary quality to mental illness, with variations being primarily quantitative, has merit.

A similar exercise to that of the APA has been occurring within another professional organization: the American Counseling Association. As a corporate affiliate of ACA, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) has been engaged in a revision of accreditation standards. In their second draft, which was supplanted by subsequent drafts, the council indicated that Clinical Counselors emphasized

> general principles of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and the general principles and practices for the promotion of optimal mental health; specific models and methods for assessing mental status and the identification of abnormal, deviant, or psychopathological behavior through an awareness of behavioral data using a variety of techniques, and interpreting findings in the current Diagnostic and Statistical Manual (DSM) categories ... (CACREP, 1991, p. 25).

From the same document, Mental Health Counselors focused on

> client characteristics of individuals served by institutions and agencies offering community mental health counseling programs and services, including but not limited to the effects of socioeconomic status, unemployment, aging, gender, culture, race, ethnicity, chronic illness, developmental transitions, and interpersonal, family, and community violence (p.27).

Subsequent publication of accreditation standards evidenced some changes in category names but retained the flavor, similar to the APA document, of definitional clarity with some blurring at the practical or applied level. One support for the belief of professional identity diffusion is the formalized difference in definitions between counseling and therapy, counselors and clinicians, accompanied by difficulties in locating discernable differences in activies of and services delivered by representatives of both definition groups.

Whether or not there is a distinction to be made, artificial or real, between therapists and therapeutic counselors or between clinical psychologists and counseling psychologists, there is a much greater challenge to the identity of professional psychologists who work in the human services sector. In direct opposition to the observations of Menniger and his associates, and seemingly in violation of the attempts by professional associations to differentiate kinds of professionals and types of service provided by them, the evolution of service delivery has been strongly influenced, even controlled by economic factors. Because insurance companies or governmental agencies provide funding for clients or employees to receive medical and psychological benefits, because using some nosology facilitates accounting and payment of large quantities of payments -- hence gigantic sums of money, and because insurance companies and governmental agencies are/have to be cost conscious, three problems accrue:

1. the labels which -- Menninger, et al. notwithstanding -- may have had some merit in identifying and treating mental illnesses, have now become primarily a vehicle for payment of fees, and secondarily a mechanism for paper accountability through peer review.
2. the diagnostic labels are affixed, in many if not most cases, by entry-level or low status professionals as a result of of a single intake interview; while not an automatic conclusion, there is at least a strong inference that the least experienced, hence least competent, professionals are managing the labelling on which the system runs.
3. because the dynamics of mental illness are unitary, some rationalizations (not defensible justifications) may be given for applying illness labels farther and farther up the scale toward normality, resulting in economic innefficiency (if not dishonesty and fraud) and the application of pjorative labels to multitudes of clients/patients for whom they were not intended and do not fit. It is not the treatment that is paid for; it is the label and the paper justification.

In particular, item # 3 should be of grave concern to the profession. If diagnostic labels are being affixed loosely (best case) or fraudulently (worst case), then either unprofessional conduct or criminal behavior is being condoned. If diagnosis and prescription form a legitimate approach to psychological intervention, then it should be done precisely enough to support professional and legal practice. If it is not a defensible approach, then the profession is promoting a sham treatment. If it is defensible and being done poorly or fraudulently, then the profession needs to police its members and their practices. The second evidence of professional identity diffusion, then, is the split between professing to operate with a diagnostic system that is highly precise and reliable in identifying severely abnormal people for whom third-party paying organizations accept eligibility, and justifying its application to large groups of clients for whom that system was not intended and does fit so as to benefit from payments earmarked for the severely abnormal population; stated otherwise, the split btween claiming to be ethically professional and working the insurance system in an unprofessional, unethical, and perhaps illegal manner.

**Proposed Resolution of Identity Dilemma**

While Menninger and his associates make a compelling case for substituting a simpler yet more accurate and therapeutically useful approach to diagnosis and intervention, it seems unlikely that such a revolution will occur. A more realistic expectation would be to reserve the DSM nosology for the truly extreme cases for which it was designed and to create a nomenclature that, at the same time, reflects the unitary nature of psychological problems, allows for differentiation of degree of concern, and provides descriptive categories on which tailored interventions can be selected or constructed.

The foundation for such an approach has been established in Responsive Therapy (Gerber, 1986). It includes two stages in therapy: (1) the diagnostic phase, a three +/- one session interaction during which the therapist uses universal counseling skills to explore client phenomenology and arrive at an understanding of client concerns and context and of the way by which the client has attempted to resolve those concerns (client circumstance and style), and (2) an active intervention phase during which the therapist directs the client in techniques or experiences designed to work for that unique client and his or her unique problems and context.

The diagnostic phase incorporates the well-known triad of cognition, affect, and behavior. These three descriptors are then used to label both circumstance and style; e.g., a client may have a problem which is primarily one of feelings or affect and, at the same time, may persist in using a cognitive style to resolve the problem -- try to explain away the feeling state. Underlying this model is the assumption that cognitive, affective, and behavioral dynamics are different between and among the three categories and that the most efficient means for intervention is to use a technique based on the same dynamics as the problem -- an affective intervention for an affective problem, etc.

Cognition Affect Behavior

In addition to the assumption that each of these categories works on different dynamics is the belief that those dynamics unique to each category encompass varying degrees of adjustment from super-normal to severely abnormal; the DSM nosolgy includes diagnostic entities which

can be divided according to their integral dynamics into these three categories. Here is a simplified description of the categories:

Cognitive Circumstance. Confusion from inaccurate or incomplete perception or from having two or more competing concepts or explanations, behavior resulting from self-defeating, cognitively mediated conclusions, or a void of data necessary for moving through a condition; being cognitively stuck as a result of too much, too little, or incorrect information or from distorted perception.

Cognitive Style. A preference for working through opportunities, demands, challenges by figuring them out and then acting on the basis of cognitive conclusions; evidenced by client statements such as, "It just doesn't make sense to me." "I just can't understand it." "Explain it to me." "I don't have a handle on it." "I'm not seeing it clearly." "If only I could figure it out."

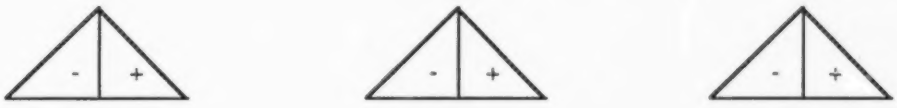
Affective Circumstance. A state of being decommissioned or limited in function because of an emotional state: high level of emotion, depressed affect, unhappiness or emptiness, or ambivalence.

Affective Style. A preference for intuition as a path to solution, impatience with explaining or defending actions, reference to an internal ease or dis-ease as a guide to action; client expressions might include, "I don't feel good about it." "It doesn't seem right." "I'm in a dither over it." "Even though everything appears okay, I don't feel complete or finished."

Behavioral Circumstance. The presence of externally cued, contingent habitual response that is self-limiting or damaging, or the absence of desirable, contingent, habitual response the absence of which is problematical.

Behavioral Style. A preference for external locus of control, situationally defined and telegraphed response with validation being success and positive reinforcement from the environment; hypervigilance and situationally controlled, internally inconsistent behavioral pattern; client statements could be, "It seemed like the right thing to do." "The situation called for it." "I don't know why I did it. I didn't think about it."

A second level of differentiation of client circumstance in the diagnostic phase is to subdivide each of the three categories into two sections: deficit and surplus.




Cognition Affect Behavior

Carefully identifying the surplus or deficit nature of client circumstance within any cognitive, affective, or behavioral category lays the foundation for selection or creation of an intervention which addresses, specifically, that particular circumstance. Such a process also illuminates differences in dynamics of various models of intervention, showing application conditions of apparent superiority or inferiority of a given model for a particular client circumstance. Similarly it provides justification for selection of intervention from an eclectic repertoire or, preferably, the selction and application of a theory-pure intervention appropriately applied to that kind of circumstance which is consonant with the theory context of the method. Brief definitions and applications follow.

Cognitive Deficit. A category of client assessment which is so obvious that it often is overlooked entirely is that of cognitive deficit. The absence of cognition in a given circumstance is related to the amount of information that is accessible. Lack of knowledge, insufficiency of information, or ignorance are descriptors for a cognitive deficit state. Provision of

information, or teaching in some form or other, is the intervention of choice for dealing with cognitive deficit. Some form of direct affront on ignorance is the most efficient form of intervention in alleviating problems of cognitive deficit.

Cognitive Surplus. Words are awkward purveyors of meaning. It might be assumed that if cognitive deficit is too little knowledge, then cognitive surplus is too much knowledge. Is it possible to have too much knowledge? Probably not. Surplus knowledge can be defined in another way. Any "knowledge" or belief that leads to self-defeating responses is knowledge that is unneeded, hence surplus. The illogical self-talk as described by Ellis (1969 ) is an example of what is here labelled surplus knowledge. Any attribution that is well established in the cognitive mediational system of a client and that leads to maladaptive or self-defeating actions is the focus of cognitive surplus interventions of the nature of reframing or disputation. "Where is it written that you must be attractive to be worthwhile?" "Do you have any evidence to support your belief that people will dislike you if they find out that you were abused as a child?" This kind of statement is common in interventions called cognitive restructuring. If there is cognition that needs restructuring, then it is surplus.

Behavioral Surplus. The key quality of behavioral problems is habit, or actions that are automatic and done in response to contingency patterns. The presence of a self-defeating habit indicates a behavioral surplus; i.e., the person would be better off without the habit. Procrastination, overeating, napping after overeating, smoking, situationally cued alcohol consumption, use of imprecise and caustic language, and defensively responding to perceived criticism are examples of unnecessary, self-defeating, excessive -- hence surplus -- behavior. The operant techniques of extinction and of reinforcing mutually exclusive responses are powerful interventions for dealing with behavioral surpluses.

Behavioral Deficit. Habits can be very benefical. Automatically responding in socially appropriate, self-enhancing ways is efficient and effective. The absence of desirable habit responses is a behavioral deficit state. Perception of and sensitivity to subtle nuances in communication, looking both ways when driving into and through an intersection, habitually brushing and flossing teeth, bathing regularly, and habitually returning the fork to the table after each bite are examples of habits, the presence of which are adjustive and self-enhancing. Therapeutic management of contingencies for response attainment is a powerful technique to fill a behavioral deficit. Such an approach often is necessary even when the client is involved in specifying the desired behavioral aquisition.

Affective Surplus. Emotions have some universal qualities. They demand expression and they seek understanding and acceptance from others. Two extremes of expression mark the affective surplus state: (1) frequent and violatile expression of feelings such as anger, self-pity, moroseness, artificially supported elation, or tenseness, and (2) absence of expression referred to as flat affect, usually indicative of the presence of intense emotions kept in neurotic check -- the lid tightly screwed on. Obviously the intervention for such conditions involves eliciting expression, ventilation, and demonstrating understanding. Ventilation without subsequent understanding usually repeats itself and a cycle of high emotionality -- high expression -- ventilation is established. In some cases, the systematic redirection or displacement of emotional expression onto a socially accepted target is used to advantage; however, such treatment basically is an incomplete intervention. Teaching skills for accurately describing feelings and working through their antecedents are proactive interventions for affective surpluses.

Affective Deficit. This state is not marked by absence of emotions, rather by a sense of vacancy of vital feelings of worth and of personal validation. The expressions of "I feel so empty," and of "My life is going well in every respect; how come I feel so incomplete or so dissatisfied?" indicate a deficit state. A theoretical referent for this condition is Maslow's need hierarchy (1954 ), specifically what he described as the middle section -- need for love and belonging. This need usually is fulfilled through position in an integrated, accepting, functional family wherein a person has a place simply by virtue of being born into that family unit. Unfortunately many families are dysfunctional, providing an insufficient structure of valid belongingness, and teaching the propogation of the same kind of interactional dynamics into the second and third generation. In Western society, this also occurs from an overreliance on achievement as the mark of success, i.e., personal value. It happens subtly and automatically when the parent or parent surrogate communicates "I like/love it/you when you clean your room/get good grades/ make winning touchdowns/win beauty awards, etc." In contrast, personal validation occurs through expressions of love and acceptance even at times of disappointing failure, violation of parental hopes and expectations, and incredible mediocrity. Contingent validation is a self-esteem strategy which, according to Maslow, will work only if the prerequisite need for love and belonging is satisfied. .

Intervention for problems of affective deficit requires creation of a personally validating relationship for the client. This is a difficult undertaking because it requires the client to disclose thoroughly his or her weak, ugly, sinful, mediocre parts as well as the practiced, achieved, socially prized parts. This disclosure must occur to a person who is perceived to be strong, wise, honest, powerful -- enough so that acceptance will be validating and, therefore, possible rejection will be devastating. Spouses, lovers, friends are not candidates to become validaters because they are part of an interdependent relationship, laced with role interactions. Therapists, ministers, parent or grandparent surrogates (usually the actual parents or grandparents are not good candidates because they would have to change from their practiced patterns) are the kinds of people who have a chance to be powerful and respected enough to be effective. Such relationship intervention seldom can be accomplished in periods of fewer than 18 months and may require two or more years, yet this is much more efficient than the inappropriate application of cognitive or behavioral interventions of shorter duration. Personal validation is accomplished only through experience. It cannot be rationalized. It cannot be contingently conditioned. Once accomplished, it tends to be resilient and durable.

While the assumption of a singular quality to mental illness or maladjustment with a range of complexity going from normal to severely abnormal implies that similar interventions would apply across the normality-abnormality continuum, there may be some differences in terms of focus and intensity between and among therapy specialities. For example, guidance functions for school counselors are primarily focused on deficit states: students who don't know what to think/believe, what to feel, and how to act. Counseling functions of school counselors would include some surplus dynamics, assuming that many of a client's thoughts, feelings, and habits are learned early in life and that falling back on them in times of crisis could result in maladaptive responses.

Counselors or therapeutic counselors or counseling psychologists working with clients who have difficulties in working through developmental tasks focus primarily deficit states. By definition, developmental tasks require a new thought pattern, emotional response, or habit reaction. Additionally, the process of development sometimes includes more and different responses than merely elaboration of existing patterns. Sometimes it is necessary to

discontinue or reframe old perceptions, extinguish old habit patterns, work through outmoded or self-defeating emotions -- in short, deal with surplus dynamics, even though the major thrust is to address deficiencies.

Relationship problems, systemic disorders, family dysfunction tend generally to result from surplus states and the clash between the patterns of different persons. A simplified division in marriage counseling calls for separating issues into "hers", "his", and "theirs." Breaking old habits, loosening and remodeling old cognitive structures and expectations, and moderating emotional responses are the frequent foci of interventions in this context. It would be foolish to be unaware of or insensitive to the impact of deficit states, though initial diagnosis likely would find self-defeat as a result of surplus conditions.

Counseling psychologists or clinicians helping clients through life crises -- such as death of a loved one, earthquake, financial collapse, disease or disability -- would be faced with disassembling nonfunctional, surplus conclusions, reactions, or habits and/or installing new conclusionis, reactions, habits which were absent (deficit) and the application of which would be adjustive.

Therapy with severely abnormal patients would include the gamut of conditions and higher degrees of self-defeat and systemic distress. Intervention would be more intense or protracted over a much longer time frame, but not appreciably different in dynamics from those applied to less severe conditions. Chemical or physical control may be required to protect the patients and others and to facilitate access to treatment. For some kinds of severe abnormalities, medical intervention is indicated.

**Cognitive, Affective, and Behavioral Categories and DSM Nosology**

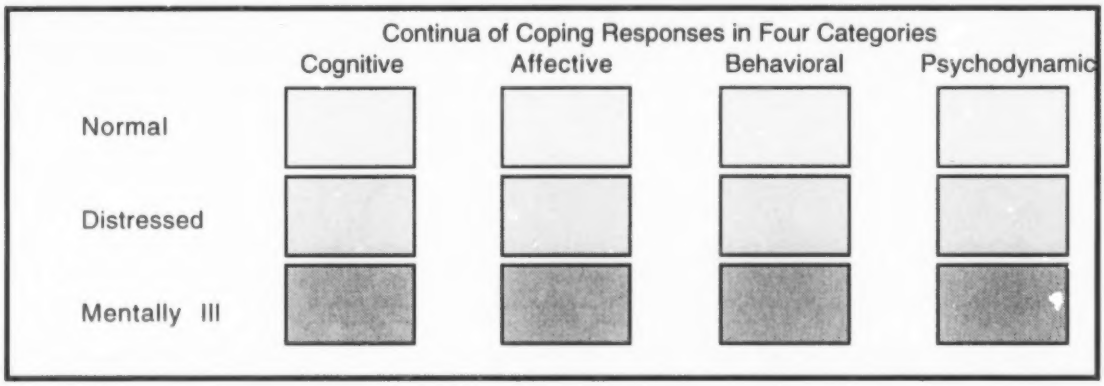
To reprise the initial references of Karl Menninger, he indicated that different mental illness designations refer not to different maladies but to quantitative variations of the same condition. Those variations are evidence of self-defeating and, at the same time, survival enhancing actions which vary with the intensity or psychological expense required by desperate people to maintain a modicum of psychological integration. People evincing mental illness are doing the best they can from their perspective of adjusting to extremely trying conditions.

> Instead of putting our emphasis on different clinical forms of mental illness, we tend today to think of all mental illness as being essentially the same in quality, although differing quantitatively and in external appearance (Menninger, K., et al., 1963, p.2).

> It is this view of mental illness as personality dysfunction and living impairment which is presented in this book. It sees all patients not as individuals afflicted with certain diseases but as human beings obliged to make awkward and expensive maneuvers to maintain themselves, individuals who have become somewhat isolated from their fellows, harassed by faulty techniques of living, uncomfortable themselves, and often to others. Their reactions are intended to make the best of a bad situation and at the same time forestall a worse one -- in other words, to insure survival even at the cost of suffering and social disaster (Menninger, K., et al., 1963, p.5).

While in basic agreement with Menniger's premises, reactions to exigencies of life can be divided into the cognitive, affective, and behavioral triad plus an additional category -- psychodynamic. Reactions within each of these four areas are dispersed across a continuum from normal to severely abnormal. This dynamic is easily manifest in classrooms wherein the

focus is abnormality and with many patently normal students agonizing over self-percieved symptoms indicative of categories of mental illness. Menninger's normal coping devices and progressive levels of dyscontrol and the somewhat artificial divisions of client concerns treated by counselors, therapeutic counselors, counseling psychologists, clinical psychologists, and psychiatrists (often using the same techniques) are further indicators of a progressive continuum from least to most severe maladaptive states.




A brief and admittedly surface analysis of responses in each category will demonstrate the dynamics of progressive continua and the differences among categories. A more comprehensive and deeper analysis could very well identify exceptions to the rule or basic weaknesses in the model. The psychodynamic category will be presented first because the continuum dynamics seem to be a little cleaner and without as much complexity as with some of the other categories.

Psychodynamic Continuum of Coping Responses

Robert Louis Stevenson, though perhaps not a credible witness in a psychologist's court, gave an entertaining treatise on the range of personality psychodynamics in his Dr. Jekyl and Mr. Hyde. Prior to the experiments in drug induced multiple personality, Dr. Jekyl is reported to have been aware of a "profound duplicity of life". In his attempts to segregate the parts of his dual nature so as to avoid cross contamination of satisfactions in both parts, he created a condition for which Stevenson's description is remarkably similar to later documentation of patients with multiple personality disorder.

Normal: Awareness of duplicity or, in Stevenson's words, a "polity of multifarious, incongruous and independent denizens." Occasional to frequent awareness of internal struggle between inclinations, but with return to stability after minor periods of confusion or ambivalence, or uneasiness. Berne (1961) describes a state where the child and parent ego states are recognized and occasionally patronized by the executive which is firmly ensconced in the adult ego state.

Distressed: Lengthy periods of uneasiness, indecisiveness, vascillation -- inability to come to resolution; inefficiency requiring unreasonable amount of energy to keep on task and to perform acceptably; seeming inablility to control some responses even though the intent to do so is clear.

Mentally Ill: Multiple personality disorder, amnesia, fugue -- lengthy periods of time "stuck" in one or inaccessible to other "identities" within the personality; extreme difficulty or inability to integrate inclinations or forces within the personality. Factitious disorders such as malingering could be a manifestation of one personality component manifesting symptoms over the objections of another component.

Cognitive Continuum of Coping Responses

At a meeting of the Association for Humanistic Psychology, the author heard Rollo May say something to the effect of: "Form is important; structure is necessary -- limits in imagination keep us from being schizophrenic; joy comes from completeness of form in our minds." By extension of this idea, paranoia is too much form; schizophrenia is too litte; intellectualization is misuse of form (defense, insulation of self), and irresponsibility (in extreme form, psychopathy)is misuse of form -- unrealistic, self-defeating limits.

Normal: Confusion resulting from conflicting information is resolved through sorting, reframing, seeking additional information, deciding or choosing what to believe. Periods of cognitive dissonance are relatively brief, terminated by the ability to decide or the decision to suspend conclusion or action, even indefinitely.

Stressed: Inability to resolve conflicting information combined with inability to leave it alone; turmoil, cognitive dissonance, or compulsive drive to resolve problem that is impervious to solution (this frequently occurs when a person is trying to cognitively solve an affective or behavioral problem); marked inefficiency due to energy being expended to grapple with the cognitive dis-ease, or self-defeating behavior resulting from persistence in using an ineffectual solution because "nothing else makes sense."

Mentally Ill: Schizophrenic disorders (too litle structure, maybe conflicting cognitive surpluses that defy resolution within the capabilities of the patient), paranoid disorders (cognitive surplus resolved by forcing interpretation of reality into rigid, self-defeating, non-responsive pattern). These conceivably might result from overreliance on and failure of the cognitive mechanisms to resolve an affective deficit. Some disorders -- like psychosexual, factitious, or impluse control disorders -- may arise from problems in the cognitive programming (cognitive surplus) of illogical assumptions which would support these kinds of extreme and desperate behavior.

Affective Continuum of Coping Responses

Emotional states seem to be directional, with surplus emotions pushing outward to expression and, hopefully, understanding by others. Absence of reassuring or validating feelings creates a seeking response. Physical touch appears to have either an enhancing or confounding effect on both kinds of emotional state.

Normal: Experience of a wide range of emotions with mostly moderate intensity, occasionally more intense in reponse to situational dynamics; a sense of being okay even in periods of distress; having an emotionally responsive context.

Stressed: Surplus state -- Periods of intense and unresolved emotion ("Fits of anger, remorse, etc."); displaced emotional expression; frequently manifest as cycle of emotional build up, climax, over-expression-ventilation (sometimes accompanied by abusive or destructive actions, or by crying spells). Deficit state -- persistent state of incompleteness, unfulfillment, even at times of personal success and accomplishment; variation between energetic seeking for fulfillment through activities and deflation or discouragement. If combined with psychodynamic duplicity, may be experienced as unsettling ambivalence.

Mentally Ill: Attention deficit disorders (deficit state - desperate attempts to get validation), affective disorders, somatoform disorders.

Behavioral Continuum of Coping Responses

In this context, behavioral signifies externally cued, contingency managed responses. It is radical behaviorism in its purest and most simplistic state and in no way to be confused by cognitive behaviorism principles. There are only two foci: habits which are present and self-defeating and habits that, by their absence, prevent self-enhancing responses in appropriately cued situations.

Normal: A large and varied repertoire of habit pattern responses combined with a high degree of perceptivity and ability to distinguish between and among seemingly similar situations which require different responses; at least one process response set to be invoked when expected response is inaccessible (ask for clarification, seek help, problem sovle).

Stressed: Persistence in a response pattern even when it is not completely successful combined with a narrowing or distortion of perception regarding feedback; stubborn; set in his or her ways; reliance on position or rank or charisma, or distraction to continue inspite of less than desirable performance.

Mentally Ill: Impulse control disorders, anxiety disorders (the Pavlov/Wolpe model of externally cued, irrational responses is a behavioral surplus condition); somatoform disorders may be conditioned; attention deficit disorders may be inadvertently established and maintained through operant dynamics (behavioral surplus) or such behavior may indicate absence of mutually exclusive, desirable, yet to be learned habits (behavioral deficit).

To the extent that people can be categorized within each of the four response continua, there may be reason to pursue and refine such categorization. Nothing herein suggests that assignment to any category is mutually exclusive; people may demonstrate multiple dynamics, certainly conceivable if there is anything to intrapersonal psychodynamics.

In some cases, eating disorders for example, the pattern of behavior may result from a compounding of elements. One description suggests that an abnormal eating habit pattern (behavioral) is established as a result of motivation due to an affective deficit combined with the illogical self-statement of, "being thin results in feeling validated"; when thin occurs and validation doesn't follow, the mechanism continues because the person has no apparent better option from her or his psycho-emotional perspective.

Some disorders are difficult to assign to a cognitive, affective, behavioral, or psychodynamic category because their manifestation may arise from more than one set of dynamics. For example, psychosexual disorders may be extreme attempts to get personal validation through sexual means -- an exaggeration of the folkism that women give sex to get love. They may be a result of programming or of early conditioning, and they may be compounded by psychodynamic forces.

**Conclusion**

The analog of a developmental stuggle for indentity vs. diffusion appropriately applies to the counseling/psychology/psychiatry professions on the basis of (1) inter- and intra-profession disputes over the proper target population and complexity of intervention strategy, and (2) the apparent imprecision, either in the nosolgy or in its application, or the dishonesty in assigning diagnostic categorical labels for the sake of third-party payment considerations. The first issue might be resolved by a major reconstruction of the diagnostic approach and a cessation of present attempts to define differences between and among subgroups of the larger professional entity. Recommendations for such have been made by Menninger and his associates and by this author. Such changes would impact the second observation to the extent that descriptive diagnoses would permit more accurate and more meaningful support for selective intervention, for communication among professionals, and for accountability; it would not automatically resolve the assertion of unethical or unlawful behavior on the part of service providers, though it might be a little more difficult to be dishonest with the use of a more responsive diagnostic system. Until the profession decides to manage itself and not respond to the dictates of an economic system which puts a priority on cost control over service to clients, there will always be the pressure to prostitute the profession and the clients.

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